The ICS Design Framework

The White Paper on Health Care Reform described the core purpose of an ICS being to:

- **improve outcomes** in population health and healthcare
- **tackle inequalities** in outcomes, experience and access
- **enhance productivity** and value for money
- help the NHS support broader **social and economic development**.

It outlined the key components to enable ICSs to deliver their core purpose, including:

- **strong place-based partnerships** between the NHS, local councils and voluntary organisations, local residents, people who access service their carers and families, leading the detailed design and delivery of integrated services within specific localities (in many places, long-established local authority boundaries), incorporating a number of neighbourhoods
- **provider collaboratives**, bringing NHS providers together across one or more ICSs, working with clinical networks and alliances and other partners, to secure the benefits of working at scale.

It also described the dual governance of an ICS NHS Board, responsible for delivering health and care improvement across NHS care, and an ICS Health and Care Partnership, responsible for outlining and managing the collaboration of services across and beyond the partnership to improve health and wellbeing jointly convened by the NHS and local authorities.

The **ICS Design Framework** sets out the next steps for the development of Integrated Care Systems, subject to Parliamentary approval in 2021. It builds on previous publications to capture the headline ambitions for how NHS England will expect leaders and organisations to operate with their partners in ICSs from April 2022.

"Successful systems will align action and maintain momentum during transition, with systems continuing to make progress in improving outcomes and supporting recovery while embedding new arrangements for strategic planning and collective accountability across partners.

Effective transition will see high performing systems taking their existing ways of working and creatively adapting these to the new statutory arrangements. It is an acceleration, in the current direction." ICS Design Framework, June 2021

The document begins to describe future ambitions for:

- the **functions of the ICS Partnership** to align the ambitions, purpose and strategies of partners across each system
- the **functions of the ICS NHS body**, including planning to meet population health needs, allocating resources, ensuring that services are in place to deliver against ambitions, facilitating the transformation of services, co-ordinating and improving people and culture development, and overseeing delivery of improved outcomes for their population
- the **governance and management arrangements** that each ICS NHS body will need to establish to carry out those functions including the flexibility to operate in a way that reflects the local context through place-based partnerships and provider collaboratives
- the opportunity for **partner organisations** to work together as part of ICSs to agree and jointly deliver shared ambitions
- **key elements of good practice** that will be essential to the success of ICSs, including strong clinical and professional leadership, deep and embedded engagement with people and communities, and streamlined arrangements for maintaining accountability and oversight

- the key features of the **financial framework** that will underpin the future ambitions of systems, including the freedom and mechanisms to use resource flexibly to better meet identified needs and to manage financial resources at system level
- the roadmap to **implement new arrangements** for ICS NHS bodies by April 2022 to establish new organisations, appoint leadership teams to new statutory organisations and to ensure that people affected by change are offered a smooth transition that allows them to maintain focus on their critical role in supporting recovery from the pandemic.

The framework, subject to Parliamentary approval, discusses:

At system level…	**An ICS Partnership**, established by the NHS and Local Government as equal partners. Operating as a forum, bringing NHS, local government and others together to align purpose and ambitions with plans to integrate care and improve health and wellbeing outcomes for their population. To improve local health and care services and influence the wider determinants of health. Responsibility to develop an Integrated Care Strategy, built from the bottom up, based on Joint Strategic Needs Assessment (JSNA). Focussed on reducing health inequalities, improving outcomes and addressing the consequences of the pandemic. Not prescriptive rules for how partnerships develop, but must be based upon principles of equality, subsidiarity, collaboration and flexibility. Mutual agreement of terms of reference, but with some national guidelines on the responsibilities of the partnership chair. Membership must include local authorities in an ICS area and the local NHS, but beyond this membership is for local determination. Significant role for public health. Legal duty to co-operate and collaborate. Chair jointly selected by the NHS ICS Body and local authorities. Option to have the same or different chair for partnership and for NHS ICS Body. Important role in hearing the voices of people with lived experience, building on existing engagement mechanisms.
	The ICS NHS Body, a new organisation binding partners together, leading on integrating the NHS in planning and providing NHS services, and collaborating on to deliver ambitions for the health of the population. Responsible for specific functions: • **Developing a plan** to meet the needs of the population • **Allocating resources**, including resources needed in each place • **Establish joint working arrangements with partners** to embed collaboration, including joint commission with local authorities, potentially at Place level. • **Establish governance arrangements** to support collective accountability between partner organisations • **Arrange the provision of health services**, including contract arrangements, convening and supporting providers working at scale and place to deliver transformation outcomes, personalised care (including Continuing Healthcare and Funded Nursing Care, • **Leading implementation of the People Plan** to align 'one workforce' • **Leading system-wide action on data and digital** to connect health and care services, understand local priorities and track delivery

	• **Invest in community organisations and infrastructure**, alongside councils and other partners • **Joint working on estates, supply chain, procurement and commercial strategies** to maximise value for money • **Planning for and responding to incidents** when such emergencies or issues arise • **Functions delegated by NHS England and Improvement**, including primary care and specialised services All CCG functions, assets and liabilities will transfer to the ICS NHS Body, along with duties on safeguarding, SEND and children in care. Statutory duties will include supporting achievement of the triple aim (better health for everyone, better care for all and efficient use of NHS resources), improving quality of services, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research and other duties defined by law. The ICS NHS Body will have a unitary Board, responsible for ensuring the body plays its role in achieving the four purposes of the wider ICS. Statutory **minimum** membership will be: • An independent chair, plus a minimum of two other independent non-executive directors • Chief Executive • Director of Finance • Director of Nursing • Medical Director • At least one member drawn from NHS Trusts and Foundation Trusts within the ICS area • At least one member drawn from general practice within the ICS area • At least one member drawn from local authorities with statutory social care responsibility within the ICS area Appointing further members will be for local determination, in line with the ICS' agreed constitution. Directors of Public Health will have an official role in the ICS Body and the Partnership. Board meetings will be held in public, and further guidance will follow. The legislation is expected to give ICS NHS bodies flexibility in how they establish and deploy such committees. They will have the power to: • appoint individuals who are not board members or staff of the ICS NHS body to be members of any committee it has established • establish joint committees with NHS Trusts/FTs to which they may delegate responsibilities (decision making) in accordance with those bodies' schemes of delegation.
Approach to People and Culture…	Better care and outcomes will be achieved by people – residents, service users, carers, professionals and leaders – working together in different ways. Successful ICSs will develop a culture that attracts people to work in and for their community and supports them to achieve their full potential. Individual employers remain the building blocks for delivering the People Plan, but ICSs have an important role in leading and overseeing progress on this agenda, with local plans in place aligned with the Partnership Strategy. ICS NHS Bodies expected to have responsibility for delivering against NHS People Plan from April 2022, with 'one workforce' approach adopted, demonstrable attention to equality, diversity and inclusion, agreeing local strategic workforce priorities, deliver high quality transaction HR, improve local workforce experience, drive culture & behaviours, ensure talent management and succession planning.

	ICS NHS Bodies will also be responsible for planning the future workforce need, with collaborative recruitment and retention, developing new ways of working to optimise staff skills, with inclusive employment models, workforce sharing arrangements and passporting/accreditation systems.
Place-Based Partnerships	Place-based partnerships are consistently recognised as key to the coordination and improvement of service planning and delivery, and as a forum to allow partners to collectively address wider determinants of health. There is no single way of defining place or determining a fixed set of responsibilities that a place-based partnership should hold. All systems should establish and support place-based partnerships with configuration and catchment areas reflecting meaningful communities and geographies that local people recognise. The membership and form of governance that place-based partnerships adopt is for local agreement, building on or complementing existing local configurations and arrangements such as Health and Wellbeing Boards. At a minimum, these partnerships should involve primary care provider leadership, local authorities, including directors of public health, providers of acute, community and mental health services and representatives of people who access care and support. The ICS NHS body will remain accountable for NHS resources deployed at place-level. Governance and leadership arrangements for place-based partnerships should support safe and effective delivery of the body's functions and responsibilities alongside wider functions of the partnership and each ICS NHS body will set out the role of place-based leaders within the governance arrangements for the body. An NHS ICS body could establish any of the following place-based governance arrangements with local authorities and other partners, to jointly drive and oversee local integration: • consultative forum, **informing** decisions by the ICS NHS body, local authorities and other partners • committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources9 • joint committee of the ICS NHS body and one or more statutory provider(s), where the relevant statutory bodies delegate decision making on specific functions/services/populations to the joint committee in accordance with their schemes of delegation. Contracts would be awarded and held, and payments made, by the ICS NHS body as the legal entity. • individual directors of the ICS NHS body having delegated authority, which they may choose to exercise through a committee. This individual director could be a joint appointment with the local authority or with an NHS statutory provider and could also have delegated authority from those bodies • lead provider managing resources and delivery at place-level under a contract with the ICS NHS body, having lead responsibility for delivering the agreed outcomes for the place. The roles of place-based leaders will include convening the place-based partnership, representing the partnership in the wider structures and governance of the ICS and (potentially) taking on executive responsibility for functions delegated by the ICS NHS body CEO or relevant local authority.
Supra-ICS Arrangements	There are some functions where ICS NHS bodies will need to work together; for example, commissioning more specialised services, emergency ambulance services and other services where relatively small numbers of providers serve large populations, and when working with providers that span multiple ICSs or operate through clinical networks.

	In Derbyshire, we have identified four initial areas for review: • Ambulance and 111 • Mental Health, Learning Disability & Autism • Acute hospital service, with focus on urgent care and planned care • GP In and Out of Hours Other provider collaboratives, including those providing cancer services, will span multiple ICS footprints where this is right for the clinical pathway for patients. The governance arrangements are for local co-design between partners. From April 2022 trusts providing acute and/or mental health services are expected to be part of one or more provider collaboratives. Community trusts, ambulance trusts and non-NHS providers (eg community interest companies) should participate in provider collaboratives where this is beneficial for patients and makes sense for the providers and systems involved.
Quality	Each NHS organisation has individual responsibilities to ensure the delivery of high quality care. ICS NHS bodies will also have statutory duties to act with a view to securing continuous improvement in quality, with arrangements for ensuring the fundamental standards of quality are delivered including to manage quality and safety risks and to address inequalities and variation; and to promote continual improvement in the quality of services, in a way that makes a real difference to the people using them. ICSs are expected to build on existing quality oversight arrangements, with collaborative working across system partners, to maintain and improve the quality of care. ICS NHS bodies will need to resource quality governance arrangements appropriately, including leading System Quality Groups (previously Quality Surveillance Groups) and ensuring that clinical and care professional leads have capacity to participate in quality oversight and improvement
The Role of Providers	The arrangements put in place by each ICS Partnership and ICS NHS body must harness the expertise, energy and ambition of the organisations directly responsible for delivering integrated care. As constituent members of the ICS Partnership, the ICS NHS body and place-based partnerships, providers of NHS services will play a central role in establishing the priorities for change and improvement across their healthcare systems and delivering the solutions to achieving better outcomes. Contracts health service providers hold (NHS Standard, or national primary care11 supplemented locally) will likely evolve to support longer term, outcomes-based agreements, with less transactional monitoring and greater dialogue on how shared objectives are achieved. The Design Framework provides a brief precis of the issues for consideration in relation to different service providers in playing a role in the system. This is not prescriptive, and poses questions and suggestions rather than answers. The Framework covers: • Primary Care • Primary Care Networks • Voluntary, community and social enterprise partnerships • Independent Sector Providers • NHS Trusts and Foundation Trusts • The new provider selection regime

	• Provider collaboratives
Clinical & Professional Leadership	All ICSs should develop a model of distributed clinical and care professional leadership, and a culture which actively encourages and supports such leadership to thrive. This includes ensuring professional and clinical leaders have protected time and resource to carry out system roles, and are fully involved as key decision-makers, with a central role in setting and implementing ICS strategy. These arrangements should support and enhance those of the organisations within the ICS footprint, which are responsible for the professional and clinical leadership of their people and services. Specific models for clinical and care professional leadership will be for ICSs to determine locally with resources provided describing the features of an effective model, informed by more than 2,000 clinical and care professionals and illustrating case studies from systems with more advanced approaches. These features include: • effective structures and communication mechanisms to connect clinical and care professional leaders at each level of the system • a culture which systematically embraces shared learning, supporting its clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities • protected time, support and infrastructure for clinical and care professional leaders to carry out their system leadership roles • clearly defined and visible support for clinical and care profession leaders, including support to develop the leadership skills required to work effectively across organisational and professional boundaries • transparent approaches to identifying and recruiting leaders, which promote equity of opportunity and a professionally and demographically diverse talent pipeline which reflects that community it serves.
Working with people and communities	The parties in an ICS, including those of the ICS Partnership, the NHS ICS body and place-based partnerships will be expected to agree how to listen consistently to, and collectively act on, the experience and aspirations of local people and communities. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. As part of the ICS-wide arrangements, each ICS NHS body will be required to build a range of engagement approaches into their activities at every level and to prioritise engaging with groups affected by inequalities. There will be a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning arrangements, and by the continuation of the existing NHS trust and foundation trust duties in relation to patient and public involvement, including the role of foundation trusts governors. Arrangements in a system or place should not just provide a mechanism for commentary on services but should be a source of genuine co-production and a key tool for supporting accountability and transparency of the system. Where decision-making affects communities, groups or specific services, these arrangements (including any formal consultation) should fully engage those affected, including populations, patients and carers across health and social care. The NHS ICS body should work with its partners across the ICS to develop arrangements for:

	• ensuring the ICS Partnership and place-based partnerships have representation from local people and communities in priority setting and decision-making forums • gathering intelligence about the experience and aspirations of people who use care and support, together with clear approaches to using these insights to inform decision making and quality governance.
Accountability	The ICS NHS Body will be a statutory organisation. ICSs more broadly bring together NHS, local government and other partners, who each retain formal accountability for the statutory functions they are responsible for. Building on the relationships and ways of working they have developed to date, these partners will need to maintain a working principle of mutual accountability, where, irrespective of their formal accountability relationships, all partners consider themselves collectively accountable to the population and communities they serve, and to each other for their contribution the ICS's objectives. Executives of provider organisations will remain accountable to their boards for the performance of functions for which their organisation is responsible. While ICS NHS bodies will, by default, lead local oversight and assurance, NHS England and NHS Improvement's future statutory regulatory responsibilities will be similar to its existing ones. This means that any formal regulatory action with providers will, when required, be taken by NHS England and NHS Improvement. Systems will also benefit from existing local authority health overview and scrutiny committees reviewing and scrutinising their work. NHS England is working with colleagues from the Care Quality Commission (CQC) and DHSC to agree the process and roles for reviewing and assessing systems.
Finance Allocations and Funding Flows	NHS England and NHS Improvement will make financial allocations to each ICS NHS body for the performance of its functions. Decisions about spending will be devolved to ICS NHS bodies. This will include the budgets for acute, community and mental health services (currently CCG commissioned), primary medical care (general practice) services (currently delegated to CCGs) and running cost allowances for the ICS NHS body. This may also include the allocations for a range of functions currently held by NHS England and NHS Improvement. Funding will continue to be linked to population need. Allocations will be based on longstanding principles of supporting equal opportunity of access for equal needs and contributing to the reduction of health inequalities. Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies. NHS England will not make a centrally set allocation to 'place' within the ICS. Money will flow from the ICS NHS body to providers largely through contracts for services/outcomes, which may be managed by place-based partnerships or provider collaboratives. The ICS NHS body will be able to commission jointly with local authorities under a section 75 joint commissioning arrangement, as CCGs can. The ICS NHS body will also be able to make grants to VCSE organisations and to NHS Trusts/FTs. In future, the ICS NHS body may wish to use its expected power to delegate its functions to statutory providers. Based on these local priorities and national rules (including the National Tariff Payment System), the ICS NHS body will agree: • priorities and outcomes to be achieved in plan against NHS budget (with clinical advice and with regard to ICS Partnership plan) • the distribution of the NHS revenue allocation (both total financial value and service lines) to: – each place-based partnership as appropriate – each NHS provider (individually contracted or via a lead provider contract, including where operating as part of a provider collaborative) – contracts with other service providers – other collaboratives partnerships. • A capital plan including how capital spend should be prioritised locally (developed through collective decision making across NHS providers, and with ability to co-ordinate with the estates and assets managed by local authorities).

	The ICS NHS body will have the freedom to set a delegated budget for place-based partnerships to support local financial decisions to spend ICS NHS resources. However, it must adopt the principle of equal access for equal need and the requirements to reduce health inequalities. Budget allocated to and managed within a place (under the agreed schemes of delegation) might include: • primary medical care • other primary care as delegated/transferred from NHS England and NHS Improvement – dental, pharmaceutical, ophthalmology services • community services • community mental health including IAPT • community diagnostics • intermediate care • any services subject to Section 75 agreement with local authority • any acute or secondary care services that is has been agreed should be commissioned at place-level. There will be a range of enablers to support a system-by-default approach, where there will be a common duty for ICS NHS bodies, NHS trusts and foundation trusts in relation to the triple aim, which requires them to have regard to the wider effect of their decisions in each of the three strands of the triple aim improving population health, quality of care and the use of resources
Data & Digital standards and requirements	Digital and data experts will have a pivotal role in ICSs, supporting transformation and ensuring health and care partners provide a modern operating environment to support their workforce, citizens and populations. From April 2022, systems will need to have smart digital and data foundations in place available at system and place level, and across provider collaboratives. ICS NHS Bodies are expected to have a renewed digital and data transformation plan, a named SRO, investment in infrastructure, the implementation of a shared care record and interoperability, a coordinated offer of digital channels for patients to help citizens manage care, a cross-system intelligence function to support strategic and operational conversations and a plan for embedding population health capabilities.
Managing the transition to ICS	The change and transition approach is guided by NHS England's Employment Commitment and a set of core principles designed to inform the thinking and actions of all colleagues throughout the process, acknowledging the wide variation in circumstances across systems. **The Employment Commitment states that:** *"NHS people within the wider health and care system (below board level) affected directly by these legislative changes, including CCGs, NHS England and NHS Improvement and NHS providers, will receive an employment commitment to continuity of terms and conditions (even if not required by law) to enable all affected colleagues to be treated in a similar way despite a variety of contractual relationships. This commitment is designed to provide stability and remove uncertainty during this transition."* Accountability for managing the change process will be with the current ICS and CCG leadership, with increasing involvement of the new leaders (eg chair, chief executive and others at board level) who may be appointed on a shadow or designate basis, pending the legislation. There will be further guidance provided on the employment commitment. While plans can be made, systems should not take decisions or enter into arrangements which presume any legislation is already in place or that it is inevitable it will become law, before the Parliamentary process has been completed.
Timetable	There is a clear timetable setting out the expectation on ICS' to deliver milestones during each period of the transition, building from existing System Develop Plans (SDPs). Further resources and guidance will be provided to support the transition, including people transition planning.